Refer to: Notes on alcoholism and drug abuse (Medical Information). West J Med 127:77-80, Jul 1977

Notes on Alcoholism and Drug Abuse

On Prescribing Medications for Recovering Alcoholic Patients

PRESCRIBING MEDICATION for a patient who is trying to maintain abstinence from alcohol or other habituating or addictive drugs may involve difficult decisions. Recovering alcoholic patients may at some time need medication for sedation, sleep, pain, cough, intestinal symptoms or depression. Many medications used for these symptoms increase the risk of creating a new habituation or addiction. Patients who have shown a dependency to alcohol frequently show a cross dependency to any medication which has the capacity to elevate or depress the patient's mood. In addition, liquid medications that have alcohol as a base should be avoided (a recent check of a local hospital pharmacy showed 87 different liquid medications that contained ethyl alcohol). In several accounts, the use of medicinal alcoholic preparations precipitated a drinking spree in recovering alcoholic patients. If a recovering alcoholic patient is taking disulfiram (Antabuse®) and does not mention it, the disulfiram-alcohol reaction could be unwittingly triggered.

If an emergency occurs making it necessary that such a patient be tranquilized, antihistamines (including diphenhydramine hydrochloride capsules [Benadryl®], hydroxyzine hydrochloride [Atarax®] and hydroxyzine pamoate [Vistaril®]) provide a relatively lower risk of patient dependency than meprobamate, barbiturates or benzodiazepine drugs. Increasing the dosage of an antihistamine is usually satisfactory for inducing sleep.

The most effective analgesics are controlled drugs—these carry an obvious warning of potential patient dependency. A physician should avoid prescribing an analgesic with which the patient has had dependency problems in the past, although this may be unavoidable if emergency treatment is necessary. Short-term, closely supervised treatment is always desirable in such cases. Prescribing a pure analgesic is preferable to prescribing compounds that contain mood elevators or depressants. Methotrimeprazine (Levoprome®), an injectable nonnarcotic analgesic, has been used in hospital with success when treating recovering alcoholics for pain.

For serious coughs codeine in tablet form is recommended. It is important to explain to patients that it is a narcotic. Some patients prefer the idea of a cough syrup. Some cough syrups that do not contain alcohol are Triminacol® cough syrup, resin complexes of hydrocodone and phenyltolxamen (Tussionex®) suspension, Actifed-C® expectorant, Hycodan® syrup and Hycomine syrup®. It should be noted, however, that most cough syrups contain other compounded ingredients which may complicate the situation.

Nausea and vomiting are well controlled by injections, tablets or suppositories of trimethobenzamide hydrochloride (Tigan®) or prochlorperazine (Compazine®). Intestinal spasm is easily relieved by dicyclomine hydrochloride (Bentyl®) tablets or injections. Again, caution should be used to avoid antispasmodic or antiflatulent compounded medications that contain barbituates, tranquilizers or liquid preparations with an alcohol base.

Most liquid prescription medications for diarrhea have an alcohol base. If nonprescription Kaopectate® proves ineffective for diarrhea, diphenoxylate hydrochloride with atropine sulfate (Lomotil®) tablets should be tried. Even though the drug is an exempt narcotic compound, Lomotil® tablets have not proved to have high addicting potential, but certainly no open prescription should be provided. Codeine tablets might also be used for diarrhea symptoms.

Nonpsychotic depression in recovering alcoholic patients is best treated by the involvement of patients in a continuing recovery program such as

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These notes were selected and prepared under the direction of the California Medical Association's Committee on Alcoholism and Other Drug Dependence (1976). In the opinion of the Committee they represent information that has gained acceptance in clinical practice.

When these items were prepared the members of the committee were Arthur Bolter, MD, Chairman; Jack D. Gordon, MD; Stanford Rossiter, MD; Jokichi Takamine, MD; Donald F. Taugher, MD; Jude R. Hayes, MD; Isaac Slaughter, MD; James T. Barter, MD, and John A. Newson, MD.

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Alcoholics Anonymous, continuing alcohol counseling or psychotherapy. If the use of antidepressant medication becomes necessary, the tricyclic drugs (for example, amitriptyline hydrochloride [Elavil®], imipramine hydrochloride [Tofranil®]) seem to be best because they have little potential for physical addiction. In general, the benzodiazepine drugs such as diazepam (Valium®), chlordiazepoxide hydrochloride (Librium®), oxazempam (Serax®), clorazepate dipotassium (Tranxene®), flurazepam hydrochloride (Dalmane®) and drugs containing meprobamate such as Deprol®, which contains meprobamate and benactyzine hydrochloride, have a high potential for dependence and should be avoided for routine outpatient use.

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Propoxyphene-Napsylate (Darvon-N® or PN) in the Treatment of Heroin Dependence

PROPOXYPHENE-NAPSYLATE (PN), a drug chemically similar to methadone, has been shown useful in the management of withdrawal from heroin dependence. It does not completely suppress withdrawal in persons addicted to large amounts of narcotics, but it appears to be adequate for control of the symptoms which occur in those addicted to heroin at the strength common in street use at present. The advantage of PN in the symptomatic management of withdrawal symptoms (such management includes combined use of anticholinergics, hypnotics and muscle relaxants) is that it is usually effective with less of those other medications. Advocates claim that PN produces fewer and less severe side effects such as sedation, constipation and sexual dysfunction, than does methadone. Patients remain free of heroin use following detoxification with PN about as often as when methadone is used in the detoxification process.

However, important risks are associated with the use of propoxyphene, in both the hydrochloride and the napsylate salt forms; large doses taken at one time appear to predispose to convulsions. Because of its convulsive potential and other complications of overdose, particularly in combination with alcohol, prudence would contraindicate prescriptions for addicts of large amounts of PN for unsupervised use. In large doses the napsylate salt is believed to be safer than the hydrochloride salt, probably because it is absorbed more slowly from the intestine.

Long-term toxicity is not known, although continuing clinical use and street use have not yet hinted at serious complications.

There is a significant potential for abuse and an illegal market for both the hydrochloride and the napsylate forms. Although no special security arrangements are required for use of PN, as they are for methadone, care should be taken to guard against the diversion to street use of any propoxyphene prescribed or dispensed. It has appeared in illegal or street traffic and in the urinalysis findings for patients in drug abuse treatment programs, apparently diverted from legal sources.

Apparently, in clinical situations many physicians are at present prescribing the drug at high doses—and at low doses in combination with other target symptom medications—for heroin detoxification. No special federal licensure is required; however, a physician does assume special responsibilities if he uses a dose higher than the manufacturer's recommended dose (100 mg every four hours). The usual PN dosage for detoxification is initially 800 to 1,200 mg a day given in two or more divided doses and tapered to zero over a 5 to 21 day period. Such use might be considered experimental or a use not approved by the Food and Drug Administration (FDA). Consequently a physician should get a specific informed consent. Implied consent to the use of standard medication is assumed when a patient comes to a physician requesting treatment. However, the implied consent does not extend to the use of investigational drugs or to the experimental use of familiar drugs.

About such research, or the use of drugs in investigational ways not described by the manufacturer in the package insert, the following information may be helpful. When the FDA approves a New Drug Application, that drug is approved for marketing and advertising for specific indications. The New Drug Application becomes a contract between FDA and the manufacturer, but the physician is not a party to the contract. He is, therefore, free to use a marketed drug in a manner dictated by standard medical practice. The physician must recognize that if he uses a drug for indications not approved by the FDA, or in doses larger than those recommended in the FDA-monitored package insert, he is probably not complying with the national medical community's